

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

City of Greenfield Employer		<input type="checkbox"/> 12 Month Plan Year <input type="checkbox"/> Short Plan Year	To be completed by Employer Employee Effective Date for Plan: _____ Date of first Payroll Deduction: _____ For 25% Concentration Test - Is this employee considered a: Key Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Highly Compensated <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee's First Name _____ Last Name _____		Social Security Number _____		
Employee's Address _____ Street _____ City _____ State _____ Zip _____	Home Phone _____		Cell Phone _____	
(Required) Employee E-mail Address for Plan notices and communications _____ You may access your FSA Account online at: https://stirlingbenefits.wealthcareportal.com or download our Mobile app – Search Stirling Benefits				
<div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married </div> <div style="display: flex; justify-content: space-between;"> Birth Date Month Day Year Gender Marital Status </div>				
Complete for additional debit card(s) Spouse/Dependent Name _____ Date of Birth _____ Social Security Number _____ Spouse and dependent debit cards will automatically have access to FSA Funds				
No, I do not want to enroll in the reimbursement sections. If a change of status occurs, I may have the right to sign on the plan at that time if my employer's plan allows. Signature: x _____ Date: _____				

Employer Plan Effective Date: **July 1, 2020**

Eligible Expenses incurred: **July 1, 2020 – September 15, 2021** must be submitted to the Stirling Benefits no later than: **September 30, 2021**

	Annual Election	# of Pays	FSA Deduction Per Pay
1. HEALTH CARE ACCOUNT: _____ ÷ 21 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> = _____ <small>(Minimum \$100 / Maximum - \$2,750)</small> <small>Effective January 1, 2011, Over-The-Counter drugs or medicines not prescribed by a doctor will no longer be reimbursable under an FSA program</small> <small>If you, or your employer on your behalf, actively contribute to an HSA account, or your spouse contributes to an HSA, you may not participate in the Health Care Account.</small>			
2. DEPENDENT (Day) CARE ACCOUNT: _____ ÷ 21 <input type="checkbox"/> 26 <input type="checkbox"/> 52 <input type="checkbox"/> = _____ <small>(Minimum \$100 / Maximum - \$5,000)</small>			

YES, I want to enroll. The IRS regulation states these conditions: **1.)** any expenses you incur must be within the plan year. **2.)** Any expenses you incur must not be covered by any other source such as insurance. **3.)** You must provide proper documentation in order to receive payment. **4.)** You cannot change or revoke your elections during the plan year unless there is a specific change of status and your employer allows such changes.
NOTE: Enrolling may have a minor effect on your social security benefits. Please seek appropriate advice.

PLEASE NOTE: If you previously requested additional debit cards for your spouse or dependents, their debit card will automatically have access to new Plan Year elected funds. Please call our office to communicate changes.

Signature: x _____ Date: _____

Accepted and agreed to by the Company's Authorized Representative

By _____ Date _____